

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2. STATE:

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3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

Title XIX

4. PROPOSED EFFECTIVE DATE

October 1, 1998

REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.300-321

7. FEDERAL BUDGET IMPACT:

a. FFY 1999 \$ 0 \*

b. FFY 2000 \$ 0 \*

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B(1)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Same

SUBJECT OF AMENDMENT:

Acute Hospital Outpatient Payment System

GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Not required under 42 CFR 430.12(b)(2)(i)

SIGNATURE OF STATE AGENCY OFFICIAL:

TYPED NAME:

Bruce M. Bullen

TITLE:

Commissioner

DATE SUBMITTED:

December 30, 1998

16. RETURN TO:

Bridget Landers  
Coordinator for the State Plan  
Division of Medical Assistance  
600 Washington Street  
Boston, MA 02111

## FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED:

December 31, 1998

18. DATE APPROVED:

June 6, 2001

PLAN APPROVED - ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL:

October 1, 1998

TYPED NAME:

Ronald Preston

20. SIGNATURE OF REGIONAL OFFICIAL:

22. TITLE:

Associate Regional Administrator for  
Medicaid and State Operations

REMARKS:

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**Methods Used to Determine Rates of Payment for  
Acute Outpatient Hospital Services**

**I: OVERVIEW**

On August 7, 1998, the Division of Medical Assistance of the Executive Office of Health and Human Services (hereafter referred to as "the Division") issued the MassHealth program's seventh Request for Application (RFA) to solicit applications from eligible, in-state acute hospitals which seek to participate as MassHealth providers of acute hospital services. The goal of the RFA was to enter into contracts with all eligible, acute hospitals in Massachusetts which accept the method of reimbursement set forth below as payment in full for providing MassHealth members with the same level of clinical services as is currently provided by those hospitals and their hospital-licensed health centers. In-state acute hospitals which: (1) operate under a hospital license issued by the Massachusetts Department of Public Health (DPH); (2) participate in the Medicare program; (3) have more than fifty percent (50%) of their beds licensed as medical/ surgical, intensive care, coronary care, burn, pediatric, pediatric intensive care, maternal (obstetrics) or neonatal intensive care beds, as determined by DPH; and (4) currently utilize more than 50% of their beds as such, as determined by the Division, are eligible to apply for a contract pursuant to the RFA. All eligible acute hospitals are participating providers.

The RFA was amended effective October 1, 1998 to update the wage area adjustment to reflect the most recent HCFA wage index information (1995).

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**II: DEFINITIONS**

**Ambulatory Patient Group (APG)** - A group of outpatient services that have been bundled for purposes of categorizing and measuring casemix and setting rates. It is based on the 3M Corporation's APG version 2.0.

**APG Outlier Payment** – A payment made to hospitals in addition to an APG payment rate for Significant Procedure APGs to compensate hospitals for certain exceptionally high-cost visits.

**Clinic Visit** - A face-to-face encounter, provided on an ambulatory basis, between an eligible member and a licensed practitioner (such as a physician, optician, optometrist, or dentist) or other medical professional under the direction of a licensed practitioner in a hospital OPD or a hospital-licensed health center for diagnosis, examination, or treatment.

**Clinical Laboratory Service** - Microbiological, serological, chemical, hematological, biophysical, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

**Community Based Entity** – Any entity which is not a hospital-based entity.

**Community-Based Physician** - Any physician, excluding interns, residents, fellows, and house officers, who is not a hospital-based physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths.

**Contract (Hospital Contract or Agreement)** - The agreement executed between each selected hospital and the Division.

**Contractor** - Each hospital that is selected by the Division after submitting a satisfactory application in response to the RFA and that enters into a contract with the Division to meet the purposes specified in the RFA.

**Division** - The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Division of Medical Assistance.

**Division of Health Care Finance and Policy (DHCFP)** - a Division of the Commonwealth of Massachusetts, Executive Office of Health and Human Services created pursuant to G.L. c.118G. DHCFP performs many of the functions performed by the former Rate Setting Commission and former Division of Medical Security.

**Emergency Department (E.D.)** - A hospital's Emergency Room or Level I Trauma Center which is

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located at the same site as the hospital's inpatient department.

**Emergency Medical Condition** - A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

**Emergency Services** - Covered inpatient and outpatient services, including Behavioral Health Services, that are furnished to a member by a provider that is qualified to furnish such services under Title XIX of the Social Security Act, and are needed to evaluate or stabilize a member's emergency medical condition.

**Hospital** - Any hospital licensed under M.G.L. c. 111, §51 which meets the eligibility criteria set forth in Section 1 of Attachment 4.19B (1) of this State Plan.

**Hospital-Based Entity** - Any entity which contracts with a hospital to provide medical services to members, on the same site as the hospital's inpatient facility or hospital-licensed health center, for the hospital's outpatient department, emergency department or hospital-licensed health center.

**Hospital-Based Physician** - Any physician, excluding interns, residents, fellows, and house officers, who contracts with a hospital or hospital-based entity to provide services to members, on the same site as the hospital's inpatient facility or hospital-licensed health center, for the hospital's outpatient department, emergency department or hospital-licensed health center. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives, and physician assistants are not hospital-based physicians.

**Hospital-Licensed Health Center (HLHC)** - A facility which is not physically attached to the hospital that (1) operates under the hospital's license; (2) meets the Division's requirements for reimbursement as a HLHC as provided at 130 CMR 410.413; (3) is approved by and enrolled with the Division's Provider Enrollment Unit as a HLHC; (4) possesses a distinct HLHC provider number issued by the Division; (5) is subject to the fiscal, administrative, and clinical management of the hospital; and (6) provides services to members solely on an outpatient basis.

**Hospital Outpatient Department** - A department or unit located at the same site as the hospital's inpatient facility that operates under the hospital's license and provides services to members on an ambulatory basis. Hospital outpatient departments include day surgery units, primary care clinics, and specialty clinics and do not include E.D.s.

**Level I Trauma Center** - A hospital with a current Level I Certification of Verification from the American College of Surgeons (ACS).

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**MH/SAP Contractor** - The entity with which the Division contracts to administer the Division's Mental Health and Substance Abuse Program (MH/SAP)

**Managed Care Organization (MCO)** – Any entity with which the Division contracts to provide primary care and certain other medical services to members on a capitated basis, including an entity that is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO) or that otherwise meets the state plan definition of an HMO.

**Medicaid (also referred to as MassHealth)** - The Medical Assistance Program administered by the Division to furnish and pay for medical services pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and the Waiver.

**Mental Health/ Substance Abuse Program (MH/SAP)** - A managed care program for the provision of mental health and substance abuse services to MassHealth members enrolled in the program.

**Observation Services** - Outpatient services consisting of the use of a bed and intermittent monitoring by professional licensed staff which is reasonable and necessary to evaluate an outpatient's condition in order to determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided under the order of a physician. Observation services usually do not, but may, exceed twenty-four hours.

**Off-Site Radiation and Oncology Treatment Center** - A hospital-owned or independently owned facility, not located at the site of the hospital's inpatient facility or hospital-licensed health center, that (1) provides radiation and oncology treatment; (2) is approved by and enrolled with the Division's Provider Enrollment Unit as an Off-Site Radiation and Oncology Treatment Center; (3) possesses a distinct provider number issued by the Division; (4) provides services to members solely on an outpatient basis; and (5) possesses appropriate DPH licensing for the provision of Radiation and Oncology Treatment.

**Outpatient Services** - Services reimbursable by the Division pursuant to the RFA which are provided to members on an ambulatory basis when rendered on-site at a hospital outpatient department or at a hospital-licensed health center. These services must be based on a classification which results from a medical determination that the services which are reasonable and necessary to diagnose and/or treat the illness or injury can be safely and effectively provided utilizing services including but not limited to emergency departments, day surgery and recovery units, observation units, clinics, health centers, physicians' and nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers and/or home care services. Such medical determination may take into account the amount of time the member is expected to medically require such hospital services, but must not be based solely on this factor. The medical determination must be consistent with 130 CMR 450.204. The classification is subject to utilization review under 130 CMR 450.207 and 130 CMR 450.211 and to the overpayment regulations at 130 CMR 450.235(B) and 450.237.

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**Pediatric Specialty Clinic** - An outpatient specialty clinic (as approved by the Division) at a pediatric specialty hospital or at a hospital with pediatric specialty (inpatient) units, which provides specialty care to Medicaid members.

**Pediatric Specialty Hospital** - An acute hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

**Pediatric Specialty Unit** - A pediatric unit in an acute hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeds 0.20, unless located in a facility already designated as a specialty hospital.

**Primary Care** - Primary care shall mean medical care required by individuals or families that is appropriate for the maintenance of health and the prevention of illness. This care includes but is not limited to physical examination, diagnosis and management of illness, ongoing health maintenance, accident prevention and referral when necessary. Primary care does not require the specialized resources of a hospital Emergency Department.

**Primary Care Clinician Program (PCCP)** - A comprehensive managed care program with primary care clinicians managing enrolled members' medical care.

**Rate Year (RY)** - The period beginning October 1 and ending September 30. RY99 begins on October 1, 1998 and ends on September 30, 1999.

**Recipient (also referred to as member)** - A person determined by the Division to be eligible for medical assistance under the MassHealth program.

**School-Based Health Center (SBHC) Services** - Health services provided to MassHealth members under the age of 21, a center located in a school setting which: 1) provides health services to MassHealth members under the age of 21; 2) operates under a hospital's license or is a hospital-licensed health center (HLHC); 3) meets the Division's requirements for reimbursement as an outpatient hospital or HLHC as provided at 130 CMR 410.401 et seq.; 4) is subject to a fiscal, administrative, and clinical management of an outpatient hospital or HLHC; 5) provides services to members solely on an outpatient basis; and 6) meets the Division's requirements in 130 CMR 450.170 through 130 CMR 450.174.

**Significant Procedure Groups** - A subset of Ambulatory Patient Groups consisting of most, but not all surgical procedures, other significant procedures, and other outpatient services that occur the day before, the day of, and the day after a significant procedure.

**Site-of-Service List** - Those services (including visits, treatments and procedures) that do not need to be provided in an outpatient department.

**Trauma Team** - A group of healthcare professionals organized to provide care in a Level I Trauma

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Center which satisfies the guidelines of "Qualifications of Trauma Care Personnel", as specified in the American College of Surgeons Committee on Trauma's "Resources for Optimal Care of the Injured Patient: 1993".

**Upper Limit** - The term referring to the level below which it is determined that the hospital reimbursement methodology will result in payments for hospital services in the aggregate that are no more than the amount that would be paid under Medicare principles of reimbursement.

**Urgent Care** – Urgent care shall mean medical services required promptly to prevent impairment of health due to symptoms that a prudent lay person would believe require medical attention, but are not life-threatening and do not pose a high risk of permanent damage to an individual's health. Urgent care is appropriately provided in a clinic, physician's office or in a hospital Emergency Department if a clinic or physician's office is inaccessible. Urgent care does not include emergent care and primary care.

**Usual and Customary Charges** - Routine fees that hospitals charge for outpatient services rendered to patients regardless of payer source.

**Waiver** - the Section 1115 Medicaid Research and Demonstration Waiver approved by the U.S. Department of Health and Human Services on April 24, 1995, and authorized by Chapter 203 of the Massachusetts Acts and Resolves of 1996.

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**III: NON-COVERED SERVICES**

The Division will reimburse Medicaid participating hospitals at the rates established in the RFA for all outpatient and emergency department services provided to Medicaid members except for the following:

**A. Mental Health and Substance Abuse Services for Members Assigned to the MH/SAP**

The MH/SAP contractor contracts with a provider network to deliver mental health and substance abuse services for Medicaid members assigned to the MH/SAP. Hospitals in the MH/SAP network are paid by the MH/SAP contractor for services to members assigned to the MH/SAP, pursuant to the contract between the MH/SAP contractor and each contracting hospital.

Hospitals that are not in the MH/SAP contractor's network (hereinafter "Non-Network Hospitals") do not qualify for Medicaid reimbursement for members assigned to the MH/SAP who are seeking mental health or substance abuse non-Emergent Care, except in accordance with a service specific agreement with the MH/SAP contractor. Non-Network Hospitals that provide medically necessary mental health and substance abuse Emergent Care to MH/SAP assigned members qualify for reimbursement by the MH/SAP contractor.

Hospitals are not entitled to any reimbursement from the Division, and may not claim such reimbursement for any services which are reimbursed by the MH/SAP contractor.

**B. MCO Services**

Hospitals providing services to Medicaid members enrolled in MCOs will be reimbursed by MCOs for those services.

Hospitals may not bill the Division, and the Division will not reimburse hospitals for services provided to Medicaid members enrolled in an MCO where such services are covered by the MCO's contract with the Division. Furthermore, hospitals may not "balance bill" the Division for any services covered by the MCO's contract with the Division. MCO reimbursement shall be considered payment in full for any MCO-covered services provided to Medicaid members enrolled in an MCO.

**C. Air Ambulance Services**

In order to receive reimbursement for air ambulance services, providers must have a separate contract with the Division for such services.

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**D. Hospital Services Reimbursed through Other Contracts or Regulations**

The Commonwealth may institute special program initiatives other than those listed above which provide, through contract and/or regulation, alternative reimbursement methodologies for hospital services or certain hospital services. In such cases, payment for such services is made exclusively pursuant to the contract and/or regulations governing the special program initiative.

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**IV: REIMBURSEMENT SYSTEM**

**A. Outpatient Services (Rates in Appendix D)**

Rates for outpatient services covered under a contract between the acute hospital and the MH/SAP contractor that are provided to Medicaid patients eligible for or assigned to the Division's MH/SAP contractor shall be governed by terms agreed upon between the acute hospital and the MH/SAP contractor.

Hospitals will not be reimbursed on an outpatient basis when an inpatient admission to the same hospital, on the same date of service, occurs following provision of outpatient services. Reimbursement for such outpatient services will be provided through the acute hospital inpatient payment system only. See State Plan Attachment 4.19A.

The following methodology will apply to outpatient services when those services are rendered at hospital outpatient departments, hospital-licensed health centers, and school-based health centers (SBHCs). To be reimbursed for any services provided at a site other than the hospital outpatient department or SBHC, the hospital must enroll that site with the Division as an appropriate provider type. If the site is not recognized by Division as a provider type, no service provided to a member at that site is reimbursable.

Hospitals will be reimbursed only for hospital services specified in Subchapter 6 of the Acute Outpatient Hospital Manual. Hospitals will be reimbursed for physician services specified in Subchapter 6 of the Acute Outpatient Hospital Manual and only in accordance with Section IV.A.1.

In addition, with the exception of Sections IV.A.1, IV.A.9 through IV.A.12 and IV.A.14 through IV.A.20, reimbursement for all outpatient services provided the day before, the day of, or the day after a Significant Procedure (see Section IV.A.8 ) shall be bundled into the reimbursement for a Significant Procedure APG, and not separately reimbursable.

**1. Physician Payments**

Physician payments are excluded from the APG methodology.

- a. A hospital may only receive reimbursement for physician services provided by hospital-based physicians or hospital-based entities to Medicaid members. The hospital must claim payment in accordance with, and subject to 1) the Physician Regulations at 130 CMR 433.000 et seq., 2) the Acute Outpatient Hospital Regulations at 130 CMR 410.000 et seq.; and the payment rules as set forth in Section IV.

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- b. Except as otherwise provided in Section IV.A.1.c below, such reimbursement shall be the lower of i) the fee in the most current promulgation of the DHCFP fees as established in 114.3 CMR 16.00, 17.00 and 18.00; ii) the hospital's usual and customary charge for physician fees; or; iii) the hospital's actual charge submitted. Hospitals will not be reimbursed separately for professional fees for practitioners other than hospital-based physicians or hospital-based entities as defined in Section II.
- c. For physician services provided by a hospital-based physician or hospital-based entity for an outpatient service included on the site-of-service list, the hospital will be reimbursed at the lower of 1) 79% of the fee established in the DHCFP Regulations at 114.CMR 16.00, 17.00 and 18.00; 2) 100% of the hospital's usual and customary charge for physician fees; or 3) 100% of the hospital's actual charge submitted.
- d. Hospitals will be reimbursed for physician services only if the hospital-based physician or a physician providing services on behalf of a hospital-based entity took an active patient care role, as opposed to a supervisory role, in providing the outpatient service(s) on the billed date(s) of service.
- e. Physician services provided by residents and interns are not reimbursable separately.
- f. Hospitals will not receive a physician payment for outpatient services provided by a community-based physician or community-based entity.

**2. Clinic Services**

**a. Clinic Visit Payment**

- i. Each hospital's cost-to-charge ratio was calculated from expenses and revenues using the FY90 RSC-403 cost report for each hospital for which adequate data were available. The cost center identified as the supervision component of physician compensation was included.

Additionally, capital from the FY90 MAC report, excluding major moveable equipment depreciation which is already in the RSC-403 report, was added to the allowed cost per visit. The hospital's Medicaid costs were then calculated by applying the cost-to-charge ratio to the hospital's Medicaid charges, from the Medicaid claims data base. Medicaid average cost and charge per visit were then calculated, and the lesser of cost per visit or charge per visit was taken as the hospital's allowable Medicaid cost per visit.

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The wage component of each hospital's allowable Medicaid cost per visit was then adjusted by the Medicare wage area index used in the RY94 RFA to remove the effect of wage differences. Finally, an efficiency standard was calculated by ranking hospitals from lowest to highest with respect to adjusted allowable Medicaid costs per visit; producing a cumulative frequency of visits for these hospitals; and establishing the weighted median adjusted allowable cost per visit as the adjusted maximum cost per visit for each hospital. The standard was established as the weighted seventy-fifth percentile of the allowable Medicaid cost per visit.

- ii. The statewide weighted mean cost per visit was then calculated by weighting each hospital's adjusted maximum Medicaid cost per visit by the ratio of the hospital's visits to statewide visits. The resulting weighted mean cost per visit became the base rate for a clinic visit, less the professional component, at all hospitals. The labor component of the base rate was then adjusted by the FY93 Medicare wage area index to derive each hospital's rate. Finally, this Medicaid rate was multiplied first by an inflation factor of 3.35% to reflect price changes between RY92 and RY93, by an inflation factor of 3.01% to reflect price changes between RY93 and RY94, by an inflation factor of 2.80% to reflect price changes between RY94 and RY95, by an inflation factor of 3.16% to reflect price changes between RY95 and RY96, by an inflation factor of 2.38% to reflect price changes between RY96 and RY97, and by an inflation factor of 2.14% to reflect price changes between RY97 and RY98. For RY99, each clinic was placed in its RY96 Medicare wage area.
- iii. Hospitals in the same Medicare designated wage area will receive the same per visit payment.
- b. Hospitals will not be reimbursed for the clinic visit payment when an inpatient admission to the same hospital, on the same date of service, occurs following the clinic visit.
- c. **Site-of-Service Limitation on Clinic Visit Payments**

Except as provided in the following paragraph, hospitals will not receive a clinic visit payment for an outpatient service when the accompanying physician service is included on the site-of-service list. The Division will reimburse the hospital for medically necessary laboratory and radiology services associated with such services, and for those ancillary services whose costs are not included in the physician payment.

Hospitals will receive a clinic visit payment for an outpatient service included on the site-of-service list only if the service is provided at the same site as the hospital's inpatient facility, hospital-licensed health center, or school-based health

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center by (i) a hospital-based physician or hospital-based entity; or (ii) an outpatient department or a hospital-based entity which is enrolled with the Division as a PCC when providing services to its enrollees.

**d. Physician Payment**

In addition to the clinic visit payment, when a hospital-based physician or hospital-based entity provides physician services during a clinic visit, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1 above.

**3. Radiology Services**

Except as otherwise provided in Section IV.A.10, hospitals will be reimbursed for radiology services as follows:

**a. Radiology Fee Schedule**

Hospitals will be reimbursed for radiology services according to the principles of the 1997 Medicare fee schedule, as identified and amended by the Division, or the hospital's usual and customary charge, whichever is lower.

**b. Physician Payment**

Notwithstanding any provision to the contrary, in addition to the above radiology service fee, when a hospital-based physician or hospital-based entity provides physician services during a radiology service, the hospital may, when the service is not reimbursed with a global fee that covers both technical and professional portions, be reimbursed for such physician services in accordance with Section IV.A.1.

**4. Laboratory Services**

**a. Laboratory Fee Schedule**

For RY99, hospitals will be reimbursed for laboratory services according to the principles of the 1997 Medicare fee schedule, as identified and amended by the Division, or the hospital's usual and customary charge, whichever is lower. The Medicare fee will be payment in full for any laboratory service rendered by the hospital.

**b. Physician Payment**

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Hospitals may not bill for hospital-based physician or hospital-based entity services related to the provision of laboratory services.

**5. Ancillary Services**

**a. Payment for Ancillary Services**

Hospitals will be reimbursed for outpatient ancillary services according to a cost-to-charge ratio or the hospital's usual and customary charges, whichever is lower except as otherwise specified in Section IV.B.3.

The cost-to-charge ratio for ancillary costs was derived by taking total ancillary costs including capital from the FY93 DHCFP-403 (Schedule II, Line 78, Column 5) and dividing by the total ancillary revenues from the FY93 DHCFP-403 (Schedule II, Line 78, Column 8) to arrive at the hospital-specific aggregate ancillary cost-to-charge ratio.

This cost-to-charge ratio will be applied to usual and customary charges for ancillary services. Such services include, but are not limited to, the following revenue centers:

Pharmacy (25X)  
IV Therapy (26X)  
Medical/Surgical Supplies and Devices (27X)  
Oncology (28X)  
Durable Medical Equipment (29X)  
Respiratory Therapy (41X)  
Pulmonary Function (46X)  
Audiology (47X)  
Cardiology (48X)  
Osteopathic Services(53X)  
Radiology Supplies (62X)  
Cast Room (70X)  
Labor Room/Delivery (72X)  
EKG (71X)  
EEG (74X)  
Gastrointestinal Services (75X)  
Treatment Room (76X)  
Lithotripsy (79X)  
Psychiatric Treatment (90X)  
Other Diagnostic Services (92X)  
Other Therapeutic Services (94X)